		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0001644

Facility Name: PERSHING CONVALESCENT HOME

Address: 3900 S. OAK PARK AVENUE (Number) STICKNEY (City) 60402 (Zip Code)

County: COOK

Telephone Number: (708)484-7543 **Fax #** (708)484-7586

IDPA ID Number: 362528894001

Date of Initial License for Current Owners: 09/02/52

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: JEFFREY STUART **Telephone Number:** (847)945-2888

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/00 to 9/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) LESTER EDELSON
(Title) ASSISTANT ADMINISTRATOR

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) JEFFREY T. STUART, C.P.A.
(Firm Name & Address) COLEMAN JOSEPH BLITSTEIN & STUART, 108 WILMOT RD, #330, DEERFIELD, IL 60015
(Telephone) (847)945-2888 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 03-16-88

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	15	Skilled (SNF)	15	5,475	1
2		Skilled Pediatric (SNF/PED)			2
3	36	Intermediate (ICF)	36	13,140	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	51	TOTALS	51	18,615	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	915	0		915	8
9	SNF/PED					9
10	ICF	9,083	3,475		12,558	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,998	3,475		13,473	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.38%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/27/64

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30/01 Fiscal Year: 09/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	111,220	8,015		119,235	(1,005)	118,230		118,230			1
2	Food Purchase		42,252		42,252		42,252	(828)	41,424			2
3	Housekeeping	28,577	6,397		34,974		34,974		34,974			3
4	Laundry	25,195	4,626		29,821		29,821		29,821			4
5	Heat and Other Utilities			34,312	34,312		34,312		34,312			5
6	Maintenance	18,459	13,624	1,976	34,059		34,059		34,059			6
7	Other (specify):* SCAVENGER			823	823		823		823			7
8	**TOTAL General Services**	183,451	74,914	37,111	295,476	(1,005)	294,471	(828)	293,643			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	461,064	22,418		483,482	(52,558)	430,924		430,924			10
10a	Therapy					22,573	22,573		22,573			10a
11	Activities	49,319	2,697		52,016	1,332	53,348		53,348			11
12	Social Services					40,214	40,214		40,214			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	510,383	25,115		535,498	11,561	547,059		547,059			16
	C. General Administration											
17	Administrative	53,729			53,729		53,729		53,729			17
18	Directors Fees											18
19	Professional Services			32,911	32,911	(10,220)	22,691	(2,250)	20,441			19
20	Dues, Fees, Subscriptions & Promotions			2,116	2,116	36	2,152		2,152			20
21	Clerical & General Office Expenses		523	17,505	18,028		18,028		18,028			21
22	Employee Benefits & Payroll Taxes			82,516	82,516		82,516		82,516			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,709	1,709		1,709		1,709			24
25	Other Admin. Staff Transportation			639	639		639		639			25
26	Insurance-Prop.Liab.Malpractice			10,785	10,785		10,785		10,785			26
27	Other (specify):* CASUAL LABOR-372; MISC-449			821	821	(372)	449		449			27
28	**TOTAL General Administration**	53,729	523	149,002	203,254	(10,556)	192,698	(2,250)	190,448			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	747,563	100,552	186,113	1,034,228		1,034,228	(3,078)	1,031,150			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PERSHING CONVALESCENT HOME #0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			10,752	10,752		10,752	(3,080)	7,672			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,206	12,206		12,206	(582)	11,624			32
33	Real Estate Taxes			45,694	45,694		45,694		45,694			33
34	Rent-Facility & Grounds			60,000	60,000		60,000	(60,000)				34
35	Rent-Equipment & Vehicles			325	325		325		325			35
36	Other (specify):*											36
37	**TOTAL Ownership**			128,977	128,977		128,977	(63,662)	65,315			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			27,923	27,923		27,923		27,923			42
43	Other (specify):* EMPLOYEE REC-5710; PENALTIES-3102			8,812	8,812		8,812	(8,812)				43
44	**TOTAL Special Cost Centers**			36,735	36,735		36,735	(8,812)	27,923			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	747,563	100,552	351,825	1,199,940		1,199,940	(75,552)	1,124,388			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,557	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(828)	2		13
14	Non-Care Related Interest	(582)	32		14
15	Non-Care Related Owner's Transactions	(5,710)	43		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,102)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,250)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,637)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (15,552)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(60,000)	34	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (60,000)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (75,552)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PERSHING CONVALESCENT HOME

ID# 0001644

Report Period Beginning: 10/01/00

Ending: 9/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	AUTO DEPRECIATION FOR NON-CARE USE	$ (3,295)	30	1
2	DEPRECIATION NOT ALLOWED ON REPORT			2
3	FROM 1993--IRS ADJUSTMENT	(1,342)	30	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,637)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 **Report Period Beginning:** 10/01/00 **Ending:** 9/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(828)	0	0	0	0	0	0	0	0	0	0	(828)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(828)	0	0	0	0	0	0	0	0	0	0	(828)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,250)	0	0	0	0	0	0	0	0	0	0	(2,250)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(2,250)	0	0	0	0	0	0	0	0	0	0	(2,250)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,078)	0	0	0	0	0	0	0	0	0	0	(3,078)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 **Report Period Beginning:** 10/01/00 **Ending:** 9/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,080)	0	0	0	0	0	0	0	0	0	0	(3,080)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(582)	0	0	0	0	0	0	0	0	0	0	(582)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(60,000)	60,000	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(63,662)	60,000	0	0	0	0	0	0	0	0	0	(3,662)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(8,812)	0	0	0	0	0	0	0	0	0	0	(8,812)	43
44	**TOTAL Special Cost Centers**	(8,812)	0	0	0	0	0	0	0	0	0	0	(8,812)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(75,552)	60,000	0	0	0	0	0	0	0	0	0	(15,552)	45

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LUCILLE ENGELSMAN	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	33	REAL ESTATE TAX	$ 45,694	LUCILLE ENGELSMAN	100.00%	$ 45,694	$	1
2	V	34	RENT		LUCILLE ENGELSMAN	100.00%	60,000	60,000	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 45,694			$ 105,694	$ * 60,000	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	LUCILLE ENGELSMAN	PRESIDENT	ADMINISTRATO	100.00		PART-TIME	P/T		$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	AMERICAN CHARTERED BK	X		OPERATIONS	$1,315.00	8/26/99	$ 150,000	$ 140,706	09/01/04	8.5000	$ 7,410	1
2												2
3												3
4												4
5												5
	Working Capital											
6	AMERICAN CHARTERED BK	X		CREDIT LINE		8/26/99	50,000	48,370	ON DEMA	VARIABLE	4,213	6
7												7
8												8
9	TOTAL Facility Related				$1,315.00		$ 200,000	$ 189,076			$ 11,623	9
	B. Non-Facility Related*											
10	HOMESIDE LENDING INC.		X	MORTGAGE-EMP REC FAC	$704.00	07/01/84	63,000	9,737	04/2003	VARIABLE	987	10
11	GREAT LAKES CREDIT UNION		X	AUTO	$535.00	06/05/98	21,725	3,665	05/05/02	8.5000	582	11
12												12
13												13
14	TOTAL Non-Facility Related				$1,239.00		$ 84,725	$ 13,402			$ 1,569	14
15	TOTALS (line 9+line14)						$ 284,725	$ 202,478			$ 13,192	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	54,198	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	43,506	2
3. Under or (over) accrual (line 2 minus line 1).	$	(10,692)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	56,386	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	45,694	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	39,576	8
	1997	40,826	9
	1998	42,935	10
	1999	43,753	11
	2000	45,694	12

9/12 OF 44440 = $33,330
11/1/01 PAYMT= 23,056
TOTAL = 56,386

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PERSHING CONVALESCENT HOME COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0001644

CONTACT PERSON REGARDING THIS REPORT JEFFREY STUART

TELEPHONE 847-945-2888 FAX #: 847-945-9512

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-06-103-035-0000	3900 S. OAK PARK AVE, STICKNI	$ 31,707.32	$ 31,707.32
2.	19-06-103-034-0000	3900 S. OAK PARK AVE, STICKNI	$ 12,732.64	$ 12,732.64
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 44,439.96	$ 44,439.96

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,240 B. General Construction Type: Exterior BR Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		2,240	1961	$	1
2		5,000	1964		2
3	TOTALS	7,240		$ 7,283	3

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	51		1964	1964	$ 199,363	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1972	43,998					43,998	9
10				1979	2,600					2,600	10
11				1980	10,349					10,349	11
12				1981	2,107					2,107	12
13				1983	6,950					6,950	13
14				1983	187					187	14
15				1985	34,659					34,659	15
16				1986	10,150					10,150	16
17	WINDOWS			1989	29,450	935	31.5	935		11,180	17
18	ROOF			1993	11,700	371	31.5	371		3,250	18
19	ROOF REPAIR AND REMODELLING			1994	17,444	447	39	447		3,355	19
20	PARKING LOT PAVING, ASPHALT AND SEAL COATING			1995	12,199	742	15	813	71	7,374	20
21	.GUTTER REPLACEMENT			1995	6,300	162	39	162		989	21
22	FIRE DOOR			1996	946	24	39	24		136	22
23	FLOORS			1996	1,000	26	39	26		144	23
24	BUILDING MATERIALS			1996	1,500	38	39	38		207	24
25	CONTRACTOR TO IMPROVE BUILDING			1996	3,000	77	39	77		413	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 393,902	$ 2,822		$ 2,893	$ 71	$ 138,048	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 28,426	$ 3,262	$ 4,061	$ 799	7	$ 22,957	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	248,832				7, 5	248,832	73
74								74
75	TOTALS	$ 277,258	$ 3,262	$ 4,061	$ 799		$ 271,789	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	PATIENT	89 BUICK SKYHAWK	1995	$ 3,591	$ 31	$ 718	$ 687	5	$ 3,431	76
77										77
78										78
79										79
80	TOTALS			$ 3,591	$ 31	$ 718	$ 687		$ 3,431	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 682,034	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 6,115	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 7,672	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 1,557	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 413,268	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	AUTO 83/84	$ 11,908	$	$ 11,908	86
87	EMPLOYEE REC FACILITY	93,214	3,729	93,214	87
88	AUTO 1982	11,643		11,643	88
89	1995 LINCOLN	29,452	1,520	15,980	89
90	1996 LINCOLN	27,725	1,775	12,885	90
91	TOTALS	$ 173,942	$ 7,024	$ 145,630	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: LUCILLE ENGELSMAN-RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

THIS HOME ONLY HIRES EXPERIENCED AND FULLY CERTIFIED AIDES.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 19,520	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		1,419	7
8	Accounts Receivable (owners or related parties)		353,851	8
9	Other(specify):		9,376	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 384,166	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost		246,869	15
16	Equipment, at Historical Cost		454,789	16
17	Accumulated Depreciation (book methods)		(569,579)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 132,079	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 516,245	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 138,914	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		7,606	30
31	Accrued Taxes Payable (excluding real estate taxes)		1,331	31
32	Accrued Real Estate Taxes(Sch.IX-B)		56,386	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes		2,762	35
	Other Current Liabilities(specify):			
36	CREDIT LINE		48,370	36
37	DUE EMPLOYEE		47	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 255,416	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		144,370	39
40	Mortgage Payable		9,737	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 154,107	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 409,523	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$ 107,458	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$ 516,981	48

***(See instructions.)**

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 104,629	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 104,629	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,037	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) DEFERRED MTN COSTS PER SCH XIX-H I	1,055	15
16	Other (describe) ON INCOME STATEMENT		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,092	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 106,721	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,206,194	1
2	Discounts and Allowances for all Levels	(19,718)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,186,476	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,519	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,519	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	EMPLOYEE REIMBURSEMENT	824	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 824	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,203,819	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	295,476	31
32	Health Care	535,498	32
33	General Administration	203,254	33
	B. Capital Expense		
34	Ownership	128,977	34
	C. Ancillary Expense		
35	Special Cost Centers	8,812	35
36	Provider Participation Fee	27,923	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,199,940	40
41	**Income before Income Taxes (line 30 minus line 40)****	3,879	41
42	**Income Taxes**	(2,842)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,037	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,987	2,091	$ 44,640	$ 21.35	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,220	12,964	240,132	18.52	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	17,563	18,118	153,718	8.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,354	2,533	22,573	8.91	8
9	Activity Director	1,046	1,119	11,432	10.22	9
10	Activity Assistants					10
11	Social Service Workers	2,334	2,674	37,888	14.17	11
12	Dietician	9,930	10,180	111,220	10.93	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,960	2,048	18,459	9.01	17
18	Housekeepers	4,773	5,036	28,577	5.67	18
19	Laundry	4,332	4,388	25,195	5.74	19
20	Administrator	5,548	5,552	53,729	9.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	64,047	66,703	$ 747,563 *	$ 11.21	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,332	11-5	44
45	Social Service Consultant	44	2,326	12-5	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	68	$ 3,658		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	545	7,903	10-5	52
53	TOTAL (lines 50 - 52)	545	$ 7,903		53

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LESTER EDELSON	ADMINISTRATOR		$ 16,548
SANDRA EDELSON	ADMINISTRATOR		20,073
JOSEFINA BACUSA	ADMINISTRATOR		11,115
LILIBETH I. JAVELOSA	ADMINISTRATOR		5,993
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 53,729

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PCS	LAWYER-RET	$ 2,250
INTERACTIVE HEALTH	HEALTH CONSULTATION	315
ILLINOIS STATE POLICE	EMPLOYEE CHECKS	36
TEAM CARE	NURSES AIDES	7,531
SOCIAL WORK CONSULT.	SOCIAL WORK	2,326
GLANTZ, RICHMAN	ACTIVIITES CONSULT.	1,332
COLEMAN JOSEPH BLITSTEIN	ACCOUNTING	19,121
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 32,911

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 12,241
Unemployment Compensation Insurance	
FICA Taxes	57,081
Employee Health Insurance	9,063
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
PAYROLL TAXES-UNEMPLOYMT	4,131
TOTAL (agree to Schedule V, line 22, col.8)	$ 82,516

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,260
Health Care Worker Background Check	36
(Indicate # of checks performed 2)	
STICKNEY BUSINESS LICENSE	481
ILL NURSING HOME ADMIN ASSOC	75
DIV OF MANAGEMENT SERVICES	100
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,152

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,684
MEALS DURING SEMINAR	25
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,709

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 Report Period Beginning: 10/01/00 Ending: 9/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	REPAIR ROOF-THERM	6/98	$ 7,382	7	$ 352	$ 1,055	$ 1,055	$ 1,055	$ 1,055	$ 1,055	$ 700	$	$
2	AIR CONDITIONER/CONDENSER												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,382		$ 352	$ 1,055	$ 1,055	$ 1,055	$ 1,055	$ 1,055	$ 700	$	$

Facility Name & ID Number PERSHING CONVALESCENT HOME # 0001644 **Report Period Beginning:** 10/01/00 **Ending:** 9/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica
action organization? NO If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? NONE ADDED

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ 582 Line V10-2

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO X If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ 27,923
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? NO For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ 0 Has any meal income been offset against
related costs? NO Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? NO If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: N/A The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

PERSHING CONVALESCENT HOME
1644
10/01/00-09/30/01

RECLASSIFICATIONS:

1-RECLASSIFY NURSING SALARIES TO THERAPY.

2-RECLASSIFY PROFESSIONAL FEES TO PROPER LEVEL OF CARE AND TO BACK-GROUND CHECKS.

3-ALLOCATE SOCIAL SERVICES FROM NURSING SALARIES.

4-RECLASSIFY CASUAL LABOR TO NURSES AIDES.

ADJUSTMENTS:

A-TO ADJUST DEPRECIATION TO STRAIGHT LINE.

B-TO ADJUST FOR INTEREST ON AUTO NOT USED FOR PATIENT RELATED ACTIVITIES.

C-TO ADJUST FOR EMPLOYEE RECREATIONAL FACILITY.

D-TO ADJUST FOR PENALTIES.

E-TO ADJUST FOR SALES TAX.

F-TO ADJUST FOR DEPRECIATION ON AUTO NOT ALLOWED ON PUBLIC AID REPORT.

G-TO ADJUST FOR DEPRECIATION NOT ALLOWED ON REPORT FROM 1993 AUDIT.

H-TO ADJUST FOR RENT TO RELATED PARTY.

I-TO ADJUST FOR LEGAL FEES TO COMBAT REAL ESTATE TAXES.

EXPLANATIONS:

P. 19 - INTEREST INCOME IS FROM MONIES RECEIVED FROM RELATED PARTY FOR MONEY DUE CORPORATION.

P. 9 - MORTGAGE INTEREST IS NOT INCLUDED IN INTEREST EXPENSE BUT IN EXPENSES FOR EMPLOYEE RECREATIONAL FACILITY.

P. 17 - XV, LINE 9--TAX REFUND DUE FROM 9/30/98.

P. 19-XVII - ADJUSTMENT OF TAXABLE INCOME ON RETURN TO PA REPORT:

NET INCOME-PA REPORT BEFORE TAXES	3879
DEF MTN COSTS	1055
EMPLOYEE REC FACILITY	5710
PENALTIES	3102
MEALS AND ENTERTAINMENT--NON DED	12
STATE TAX	-916
TOTAL	12842